Avocet Trust

Salthouse Road

Inspection report

199a-203a Salthouse Road
Hull
Humberside
HU8 9HG

Tel: 01482329226
Website: www.avocettrust.co.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

199A - 203A Salthouse Road is located in the east of the city of Hull and is registered to provide care and accommodation for up to a maximum of eight people with a learning disability. Accommodation is provided in three purpose built bungalows.

We undertook this unannounced inspection on the 5 February 2016. At the time of the inspection there were eight people living at the service.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found improvements were required in some areas of medicines management to ensure recording was accurate and stock control was efficient. People received their medicines as required although there had been some occasions when staff could have contacted their GPs to seek advice.

There were policies and procedures to help guide staff in how to keep people safe from the risk of harm and abuse. Staff were knowledgeable about the different types of abuse and knew how to raise concerns. We found staff recorded when incidents occurred between people who used the service and incidents were referred appropriately to the local authority safeguarding team.

People had risk assessments in place which helped to guide staff in how to minimise the reoccurrence of incidents. Staff told us they had read risk assessments for people who used the service and were aware of their responsibilities and the steps to take to minimise risk. However, we found one instance where risk assessments could be improved.

We found the environment was clean and tidy, but improvements were required to stop the practice of fire doors being wedged open and to the safe storage of disposable gloves and bags. Further action also needed to be taken to promote good infection control practices when washing clothing and other items. Equipment used in the service was maintained.

We looked at the recruitment checks the service had carried out for new staff. These showed robust measures were in place to ensure staff were suitable to work with vulnerable people. Staff received an induction and had access to training, supervision and support to help them to develop and feel confident when caring for people and carrying out their roles.

We found people's health care needs were met. They had access to a range of health professionals and staff were clear about how they monitored people's health in order to seek medical attention quickly. Comments from health professionals who visited the service were positive about the staff team being helpful and

receptive to their help and support.

We found staff had a caring and considerate approach towards people who used the service and found ways to promote people's independence, privacy and dignity. Staff provided information to people and included them in decisions about their support and care.

People had assessments of their needs and plans of care were produced; these showed people and their relatives had been involved in the process. We observed people received care that was person-centred.

Staff had received training in legislation such as the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and the Mental Health Act 1983. They were aware of the need to gain consent when delivering care and support and what to do if people lacked capacity to agree to it. When people were assessed by staff as not having the capacity to make their own decisions, meetings were held with relevant others to discuss options and make decisions in the person's best interest.

Menus were varied and staff confirmed choices and alternatives were available for each meal; we observed drinks and snacks were served between meals. People's weight was monitored and referrals to dieticians made when required.

We found staff supported people with meaningful activities including access to community facilities and keeping in touch in family and friends.

Relatives knew how to make complaints and told us they had no concerns about raising issues with the staff team or the registered manager.

A revised quality assurance system had recently been introduced which consisted of seeking people's views and carrying out audits and observations of staff practice. This had been introduced to identify shortfalls so actions could be taken to address them.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were some issues identified in the recording of medicines management which needed to be improved.

Staff knew how to safeguard people from the risk of harm and abuse. Some minor incidents between people had not been assessed and scored using the specific risk management tool provided by the local safeguarding team.

Risk assessments were completed; however we found further detail needed to be included for staff about recognising the signs of changing behaviours.

Staff were recruited safely and deployed in sufficient numbers to meet people's current level of needs.

Is the service effective?

Good

The service was effective.

People's health and nutritional needs were met. They had access to a range of health care professionals in the community when required. Menus were varied and provided people with a choice of meals and alternatives.

People were supported to make their own decisions about the care they received. When people were assessed as not having capacity to do this, the registered provider acted within the principles of the Mental Capacity Act 2005. Applications to deprive people of their liberty had been submitted for appropriately.

Staff received induction, training, supervision and appraisal to help develop their skills and experience in caring for people with complex needs.

Is the service caring?

Good

The service was caring.

Staff were described as being kind and compassionate. We observed their approach was friendly and patient. People's privacy and dignity was maintained.

People were provided with information and explanations to help them make choices and they were involved in planning their care.

Advocates were accessible to people without relatives to support them in decision making processes.

Personal information was held securely.

Is the service responsive?

Good

The service was responsive.

People had assessments of their needs and care plans to guide staff in how to best support them in line with their preferences and wishes. People received person-centred care.

There was a range of activities to ensure people participated in meaningful occupations. There was also access to trips out into the local community.

There was a complaints policy and procedure and people felt able to raise concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The registered manager promoted an open and transparent culture within the service leading by their own example. Although they welcomed suggestions from people who used the service, their relatives and staff, there were no records available to demonstrate how people's suggestions had been considered or implemented.

When accidents or incidents had occurred in the service, records of actions taken to review and investigate these were not always in place.

There was structure to the organisation and levels of support. The registered provider was fully involved in overseeing the service.

A new quality improvement programme had been recently

introduced which consisted of audits, observations of practice, meetings and questionnaires

Salthouse Road

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 5 February 2016 and was unannounced and was carried out by two adult social care inspectors.

We looked at notifications sent in to us by the registered provider, which gave us information about how incidents and accidents were managed.

Prior to the inspection, we spoke with the local safeguarding team and the local authority contracts and commissioning team regarding their views of the service. We also received information from three relatives and three professionals following our inspection. There were no outstanding concerns from any of these people.

During the inspection we observed how staff interacted with people who used the service, we used the Short Observational Framework for Inspection (SOFI) and to evaluate the level of care and support people received. We spoke with the registered provider, the registered manager and four members of staff. Three relatives and three professionals were spoken with following the inspection.

We looked at the premises including people's bedrooms (with their permission), care records in relation to two people's care and medication. Records relating to the management of the service including; staff recruitment, supervision and appraisal, staffing rotas, records of minutes of meetings, staff induction records, staff training records, quality assurance audits and a selection of policies and procedures were looked at. We also looked at how the service used the Mental Capacity Act 2005 and Deprivation of liberty Safeguards (DoLS) to ensure that when people were assessed as lacking capacity to make informed decisions themselves or when they were deprived of their liberty, actions were taken in their best interests. A tour of the buildings was done to make sure it was clean and tidy.

Requires Improvement

Is the service safe?

Our findings

People who used the service had communication and language difficulties and because of this we were unable to obtain their views about their experiences. We relied mainly on observations of care and our discussions with people's relatives and staff to form our judgements.

Relatives told us, "I have no qualms whatsoever," and "Yes, I am sure they are completely safe." They also said there was sufficient staff available and considered their relatives to be well cared for. One person commented, "Following a fall during the night I do wonder if my relative needs more support during the night or a reassessment. However, since the fall the staff have been extremely vigilant and there have been no further incidents." Another told us, "The staff are almost like a family really. They have very close relationships with them and care for them."

Professionals told us, "There have been a lot of new staff appointed at the service and this doesn't bode well for continuity as some of the new staff are unable to pick up subtle changes as well as the established staff can."

The registered provider had policies and procedures to guide staff in how to safeguard people from the risk of harm and abuse. Staff confirmed they had completed safeguarding training with the local authority and they were aware of what to do if they had any concerns. They were also aware of the whistle blowing policy and procedure. In discussions, staff demonstrated knowledge of the different types of abuse and signs and symptoms that may alert them to concerns.

Risk assessments were seen to be in place to support people to maintain their independence and to minimise risks. These had been developed with input from the person, professionals and staff. Records showed risks were generally well managed through individual risk assessments that identified the potential for these and provided information for staff to help them avoid or reduce the risks. Some minor incidents between people had not been assessed and scored using the specific risk management tool provided by the local safeguarding team; however appropriate referrals had been made as required. Although a record of actions and incidents was maintained and changes made to risk assessments following incidents were seen, a summary of actions taken following the incident was not always maintained.

Risk assessments we saw included falls, activities, accessing the community, correct posture, nutrition and changing behaviours. We saw that for one person the risk assessment did not detail how staff could recognise triggers or signs which may indicate they may be becoming anxious or distressed, or fully detailed circumstances that may trigger these behaviours and ways to avoid or reduce these. We spoke to the registered manager about this who gave assurances this would be addressed.

Discussions with the registered manager and staff confirmed that restraint was not used within the service. Records seen confirmed this and showed that low level interventions and distraction techniques were effective in diffusing incidents of behaviours that were challenging to the service and others.

We looked at the recruitment checks the service had carried out for new staff. These showed robust measures were in place to ensure staff were suitable to work with vulnerable people. New staff had completed an application with a detailed employment record and references had been sought. Disclosure and Barring Service (DBS) checks had also been carried out prior to new members of staff starting work. DBS checks consisted of a check on people's criminal record and a check to see if they have been placed on a list of people who are barred from working with vulnerable adults. Interview records were maintained and contracts and terms and conditions for employment were in. Staff received an induction and had access to training, supervision and support to help them to develop and feel confident when caring for people and carrying out their roles.

We reviewed the management of medicines and found this to be completed safely and appropriately. Medicines were obtained, stored and were administered to people in line with their prescriptions. We found some improvements needed to be made to the recording of medicines, transcribed information onto medication administration records (MARs) records. For example we saw where changes had been made to one person's medication, there were two signatures or dates of when the changes had come into effect. We saw medication that had been discontinued was still detailed on MARs records and where eye drops had been prescribed, there was no information to identify which eye or if both eyes required this medicine to be administered. Where medicines had been prescribed on an 'as and when' required basis and detailed a maximum and minimum dose to be administered, records did not detail which level of dose had been administered.

We found there were sufficient staff on duty to meet the current needs of people who used the service. Rotas indicated there were five care staff and a senior on duty during the day. One waking staff member was available in each of the three bungalows during the night. The registered manager told us they were currently recruiting to two staff vacancies. The shortfalls were being covered by existing staff, bank staff and on occasions agency staff. They told us they always tried to obtain the same bank and agency staff to cover shortfalls in order to provide continuity to the people who used the service.

The environment was found to be homely, safe, warm, clean and fresh smelling throughout. Equipment used in the service was maintained and any repairs carried out in a timely way. We found some improvements needed to be made in the way people's personal items were washed. During our inspection we found an incontinence aid was being washed with personal clothing and protective aprons people used at mealtimes on a thirty degree wash cycle. The items had been washed in a disposable bag in a domestic washing machine. When we spoke to staff they were clear that this was not good infection control practice. We spoke to the registered manager who gave assurances they would investigate the incident and re visit appropriate infection control management with the staff team to ensure this did not happen again.

We saw a number of doors were held back with wedges. When we spoke to the registered manager about this they confirmed they had requested a number of door closure systems to replace these. The individual with responsibility for fire safety within the organisation visited the service during the inspection and confirmed with us the door closures had been delivered and would be fitted within the next seven days.

We saw there were plentiful supplies of personal, protective equipment such as gloves, aprons, paper towels and hand sanitizer. However there were supplies of disposable bags, gloves and aprons kept in bathrooms which were accessible to the people who used the service and had the potential to present risks. When we discussed this with the registered manager they arranged for these to be removed to a more secure area.

Good

Is the service effective?

Our findings

People who used the service had communication and language difficulties and because of this we were unable to obtain their views about their experiences. We relied mainly on observations of care and our discussions with people's relatives and staff to form our judgements.

Relatives we spoke with told us they thought staff understood their relative's needs and had the skills and abilities to meet them. Comments included; "I can't fault any of the staff, they all know her so well." Another told us, "They are very good at keeping us up to date with everything that is going on." When asked about the food provided in the service, relatives told us, "The meals are very good and they eat out on a regular basis too."

Professionals told us staff were welcoming and receptive to help and support offered, but they had required a lot of support to get changes implemented. They informed us they were involved in best interests meetings and their input was welcomed." Comments included, "We have worked with the staff team to ensure all equipment is used in the least restrictive way and the staff now have a good understanding of MCA and DoLS."

We saw people's nutritional needs were assessed and kept under review and there was a good range of food and drink supplies in the service. Staff confirmed that menus were planned in consultation with people who used the service and offered at least two choices of food at mealtimes, but further options were always available and were provided. The daily records we reviewed confirmed that alternative choices were regularly provided to people. Special diets were seen to be catered for and meals of different textures produced to assist people with swallowing difficulties.

Staff we spoke with had a good understanding of people's preferences for food and their individual dietary requirements. They gave an example of one person who particularly disliked cold drinks, so they ensured they were always offered their choice of drink at their preferred temperature. We saw staff maintained a record of food and fluids where a need for this had been identified. People who used the service had their weight monitored and appropriate action was taken when there were concerns.

We saw the health care needs of people who used the service were met. Appropriate timely referrals had been made to health professionals for assessment, treatment and advice when required. These included, GPs, dentists, emergency care practitioners and opticians. Records indicated people saw consultants via out patient's appointments, accompanied by staff, and had regular health checks. We saw each person had a health action plan which detailed their health care needs and who would be involved in meeting them. This helped to provide staff with guidance, information about timings for appointments and instructions from professionals.

The Mental Capacity Act 2005 [MCA] provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The Care Quality Commission is required by law to monitor the use of Deprivation of Liberty Safeguards [DoLS]. DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. Records showed relevant staff had completed MCA and DoLS training. The registered manager was aware of their responsibilities in relation to DoLS and understood the criteria. They told us applications for DoLS had been made for seven people who met the criteria and they were awaiting authorisation by the local authority. We saw that where people had been assessed as lacking capacity to consent to care and make their own decisions, best interests meetings had been held to discuss options; these included ensuring relatives and other relevant people had input into discussions about decisions. Professionals and relatives we spoke with confirmed their involvement in this process.

During discussions with staff we found they had a good understanding of the principles of the Mental Capacity Act 2005 [MCA] and were able to describe how they supported people to make their own decisions. Throughout our inspection we observed staff offering choices to people and supporting them to make decisions about what they wanted to do, for example; what they preferred to eat and drink and the activities they wanted to engage in.

We looked at staff training records and saw staff had access to a range of training which the registered provider considered to be essential and service specific. This included MAPA [Management of Actual or Potential Aggression Training Programme], epilepsy, moving and handling, safeguarding of vulnerable adults, challenging behaviour, first aid, health and safety, infection control, the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards [DoLS]. Staff were also either working towards or had completed an NVQ [National Vocational Qualification in Health and Social Care].

Staff confirmed they received regular supervision including annual appraisals to review their performance and identify any further training needs. Staff described how they had been fully supported by the registered manager and the staff team when they had first been appointed. They told us following their appointment they had completed the organisation's induction which covered essential training that included topics such as; medication, safeguarding and moving and handling. They then had a period of shadowing experienced staff in the service and completed a work based induction booklet. Additional specialist training was also made available to staff during this time including, epilepsy and MCA and DoLS. Staff records reviewed confirmed this process.

The registered manager told us the frequency of training had been revised so mandatory training would be updated on an annual basis. They also told us that where observations of practice identified the need for further training or support, this was provided. Staff files seen confirmed this process to be in place. The registered manager told us how experienced staff had put together a leaflet describing their role and what this involved on a typical day to share with new staff, to give them an understanding of what they would be expected to do. When we spoke to newly appointed staff about this they told us this had been shared with them during their induction and they had found this useful.

The staff we spoke with confirmed they attended both face- to-face and E-learning training to maintain their skills. Staff told us their training was relevant and covered what they needed to know. They told us that when people's needs changed or they developed particular health needs, training was provided to ensure staff understood how they could support people effectively. Staff confirmed they were further supported through regular team meetings which were used to discuss a number of topics including; changes in

practice, care plans, rota's and training.

Staff we spoke with understood people's preferred routines and the way they liked their care and support to be delivered. Staff described in detail how they supported people in line with their assessed needs and their preferences. We saw staff communicated with people effectively and used different ways of enhancing communication with people who used the service. For example, using keyworker time to talk to people about their care and discussing their views and wishes. Communication support plans supported staff to create meaningful interactions with the people they were supporting. Care records contained clear guidance for staff on how to support people with their communication and how to engage with this. This supported people to make day to day choices.

Bedrooms were personalised and people who used the service had been involved in choosing their own colour schemes and decoration for their rooms. During discussion staff told us about one person who had initially declined to engage in any attempt to introduce anything into their bedroom, but how over time they had been involved in adding personal touches to their personal space. Many people had certificates of their achievements displayed in their personal areas.

Good

Is the service caring?

Our findings

People who used the service had communication and language difficulties and because of this we were unable to obtain their views about their experiences. We relied mainly on observations of care and our discussions with people's relatives and staff to form our judgements.

Relatives commented positively on the care their family member received. Comments included, "The staff are great and I know my relative is very happy there" and "They can't do enough for them and you can see they genuinely care." Another told us, "I was very impressed with the way my relative is cared for."

Professionals told us the staff team were receptive to help and support offered and they were very welcoming. Comments included, "The staff know where to get information about people when we request this, they are well organised and pick changes up very quickly."

Staff demonstrated they understood how people's privacy and dignity was promoted and respected, and why this was important. They told us they always knocked on people's doors before entering their room.

During the inspection we used the SOFI which allows us to spend time observing what is happening in the service and helps us to record how people spend their time, the type of support received and if they had positive experiences. We spent time in one of the dining rooms and we observed staff interacted positively and sensitively towards the people who used the service. We observed people going out from the service to engage in different activities including shopping and a cycling activity. When staff changed we saw one person who used the service become very excited when they saw their key worker come on duty and rush to greet them.

We saw staff responded to people's queries and offering reassurances when this was required. One person went to sit at the table and we saw staff approach them and explain to them that the evening meal was not quite ready and ask them if they would like a drink while they were waiting, to which the person was seen to nod in response. The staff were seen to respond to this and went to prepare a drink for the person.

People who used the service were seen to approach staff with confidence; they indicated when they wanted their company for example, when they wanted a drink and when they wanted to be on their own and staff were seen to respect these choices. People were observed to be given time to respond to the information they had been given or the request made of them, in a caring and patient manner. Requests from people who used the service were seen to be responded to quickly by staff.
We saw people who used the service looked well cared for, with different hairstyles and clothing that was in keeping with their own preferences and age group. Relatives we spoke with commented "They always look lovely and their hair is super." Staff told us the people who used the service were always supported to on shopping trips to enable them to make their own purchases of clothing and personal items. When we spoke to staff about trips, they told us they had planned with people to support them with outings day trips and holidays and shopping trips on an individual basis or to go out for lunch.

Staff told us about the importance of maintaining family relationships and supporting visits and how they supported and enabled this; in home visits, meeting up with family members during holidays and supporting people to purchase gifts and cards for special occasions. They told us how they kept relatives informed about important issues that affected their family member and ensured they were involved in all aspects of decision making. Relatives were also invited to reviews and if they were unable to attend their views were sought and shared in reviews and other meetings. Records seen confirmed this. One relative told us how staff had supported their family member to visit them and stay overnight even though they lived a considerable distance away. Staff had planned a further visit with the family so their family member could meet up with a relative who lived overseas.

Staff spoke about the needs of each individual and demonstrated a good understanding of these, their previous history, what they needed support with and encouragement to do and what they were able to do for themselves. Some of the staff team had worked at the service for a number of years and this had led to the development of positive relationships between staff and the people who used the service.

During discussion with staff they confirmed they read care plans and information was shared with them in a number of ways including; a daily handover, communication records and team meetings. People's care records showed that people were supported to access and use advocacy services when required to support them to make decisions about their life choices. Relatives spoken with confirmed this.

Good

Is the service responsive?

Our findings

People who used the service had communication and language difficulties and because of this we were unable to obtain their views about their experiences. We relied mainly on observations of care and our discussions with people's relatives and staff to form our judgements.

Relatives told us staff were responsive to people's individual needs. They said there was a good range of activities for their family member to participate in and they led active and fulfilling lives. Comments included, "They are involved in a lot of activities and are always out and about. I know my relative enjoys the pamper sessions particularly. I think they have a better social life than I do." Another told us, "We are fully involved in all aspects of their care and I think they have come on leaps and bounds, they are a good bunch of girls looking after them."

When we asked relatives if they felt able to raise concerns, they told us, "[The registered manager] is fantastic, completely welcoming and able to answer any questions or queries we may have. I have never needed to raise any concern, but am confident she would deal with them, should the need arise."

Professionals told us the staff were responsive to people's needs and engaged well with them. They told us staff were always welcoming and the service was very homely. Comments included "The staff work really well and are responsive to people's needs, picking up on changes quickly."

We looked at the care files for two people and saw care was provided in a person centred way. Individual assessments were seen to be carried out to identify people's support needs and care plans were developed following this, outlining how these needs were to be met. People who used the service were encouraged to follow their hobbies and personal interests. Staff supported people to attend sporting events such as cycling, swimming, meals out, day trips, shopping trips and annual holidays. During the inspection we saw people were engaged in a number of activities both as part of a group and on an individual basis, this included; cycling, going out for lunch, a shopping trip and going out for walks. Some people were funded to have additional staff hours for this. For example, during the inspection one person went out for several hours on a one- to-one basis with staff.

People had communication passports which detailed how they communicated and information about them as individuals, including their likes, dislikes and what interested them. We saw assessments had been used to identify the person's level of risk and where risks were identified, risk assessments had been completed. These included potential risks within the service, the local community and for activities, for example; cycling. All but one of the risk assessments reviewed contained detailed information for staff on how risk could be reduced or minimised. When we spoke with the registered manager about this she offered assurances that the risk assessment would be reviewed and updated to rectify this.

We saw that care plans and risk assessments were reviewed monthly and when changes in need had been identified, changes were made to reflect this. The registered manager told us, "We will update risk assessments and support plans if there has been a change in people's needs and then continue to review

them to make sure that these are accurate." When we spoke with staff about this they were aware of recent changes having being made to people's care and support plan and the reason for this, providing detailed examples. This information corresponded to the details included in people's individual care and support plans.

We observed staff followed the person-centred care plans in practice during their support of people at mealtimes and when they were communicating with them. For example, one person had very detailed information about their nutritional intake and the required texture of their food to prevent them from choking; we observed this information was followed in staff practice while supporting the person.

Staff completed daily recording and monitoring sheets, which prompted them to include specific information. We saw this included what people had eaten for their meals, what their general health was like, how they had spent their day, what contact there had been with family and friends, what activities they had completed and any community facility they had accessed. Staff also recorded any marks on a body map and monitored people's weight and their bowel function to alert them to concerns which might require prompt action. Details of any health professional appointments or visits were also included.

There was a complaints policy and procedure and staff were familiar with the actions to take if they received a complaint or concern. The policy and procedure was available in easy read format to help the people who used the service to understand the contents. In discussions staff told us they received very few complaints. The registered manager said, "The people we support are not all able to make formal complaints so we have to be aware of their body language to see when they are unhappy with something. We also ensure keyworkers spend time with people on an individual basis, discussing their care and support plans and to encourage people to express their views and opinions." They told us any complaints received were recorded in the complaints log and shared with their line manager. There were specific letters to send to people to acknowledge the complaint and keep them informed of any investigation and outcome.

Requires Improvement

Is the service well-led?

Our findings

People who used the service had communication and language difficulties and because of this we were unable to obtain their views about their experiences. We relied mainly on observations of care and our discussions with people's relatives and staff to form our judgements. During the inspection we saw when the registered manager spent time in the bungalows; people who used the service acknowledged her and approached her in a confident manner. We observed the registered manager greet people and engage with them.

Relatives spoken with knew the registered manager's name and told us they were able to express their views either when they visited, at formal reviews, during telephone conversations or in surveys. Comments from relatives were, "I can't speak highly enough about the manager, she is very dedicated", "Yes, I get sent a survey and it gets filled but I'm not sure what happens then", and "I'm invited to meetings."

Professionals told us they considered the registered manager to be very supportive, on board and willing to clarify with professionals any suggestions or advice about people's care.

There was a clear hierarchy within the organisation, overseen by a Board of Trustees. We spoke with the registered manager about the culture of the organisation and their management style. They said, "We have an open culture where we seek staff views and they can put them across. I personally value people as individuals and promote a person centred approach, focussing on empowerment and the promotion of independence. I encourage my staff team as individuals to encourage this culture within their individual practice. As a manager I am very hands on and lead by my example, to share my experience and skills. I consider myself to be very client orientated; they are the focus of everything we do. I share information with staff and consider myself to be fair and to be a good listener. I make time for staff and have an open door policy. My manager does the same for me."

We found the organisation encouraged good practice. For example, there was a system in the organisation to nominate staff for specific awards for recognition of good practice. Staff were provided with handbooks which explained what the expectations were of their practice and described the organisation's vision. This was described as promoting a 'lifetime support to vulnerable people to enable them to live fulfilled and valued lives through making personal choices, an inclusive society where people have equal chances to live the life they choose'. Staff received awards for long service within the organisation.

We found the registered manager was aware of their role and responsibilities and notified the Care Quality Commission, and other agencies, of incidents which affected the welfare of people who used the service. Our records showed notifications had been received regarding an accident that had occurred in the service. They indicated what action had been taken and how staff practice was to be monitored. Records held in the service showed there had been no further accidents involving this person, which showed appropriate actions had been taken. We have found the registered manager responded to requests for information when required.

We saw improvements needed to be made in the way the registered provider acted upon feedback from surveys. For example, where the most recent surveys had been returned from the previous quality assurance system and where recommendations had been made, there was no records to demonstrate what actions had been taken from these. This did not demonstrate the system was effective or the registered provider acted upon recommendations made for improving the service. When we spoke to the registered manager and nominated individual about this, they told us the new quality monitoring system would address this.

They explained and showed us paperwork in relation to the revised corporate quality monitoring system which had recently been introduced to the service that comprised of a number of audits and surveys at regular intervals.

The registered manager showed us an example of where they had completed an audit of the environment and identified areas for improvement. They had recently submitted this to their line manager and the estates manager and were awaiting a meeting date to discuss this further, so an action plan could be developed for the work to be done.

The nominated individual and registered manager both carried out monthly audits of the service including; care plans, medication, the environment, accidents and incidents, staff training and supervision. Results from these were then discussed at senior management team meetings for further action where this was required. We saw improvements had been made in the way accidents or incidents that had occurred in the service were monitored, as records of actions taken to review and investigate these were now in place. However we found previous incidents had not always been monitored or detailed in the same detail.

Staff told us there was a supportive culture within the service and the registered manager was fair, supportive and approachable. They told us they were able to raise issues and worked well together as a team. We saw staff were able to express their views in team meetings, supervision sessions, appraisals and on a day to day basis. Staff told us, "It's a good environment here; the manager is available for support and advice when needed", "There is an open-door policy and I do like working here" and "We have a good team here and the service users seem happy with the care." There were various methods of ensuring information was passed on to and between staff. These included handovers at each shift, a communication book, briefings, newsletters and team meetings. The registered manager told us they attended manager's meetings on a regular basis where they discussed policies and procedures and shared best practice information.

The registered manager told us the meetings for people who used the service had not been very successful but keyworkers spent individual time with people to obtain their views, and when required advocates were available.